5.03: continued

(3) Special Cost Reporting Requirements.

(a) Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider may not claim reimbursement for the expenses of such programs.

1. If the Provider converts a portion of the facility to another program, the Provider must identify the existing Equipment no longer used in Nursing Facility operations and remove such Equipment from the Nursing Facility records.

2. The Provider must identify the total square footage of the existing Building, the square footage associated with the program, and the Equipment associated with the program.

3. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.

(b) Hospital-Based Nursing Facilities. A Hospital-Based Nursing Facility must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report. The Provider must:

1. identify and claim reimbursement only for the existing Building and Improvement costs associated with the Nursing Facility. The Provider must allocate such costs on a square footage basis.

2. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the facility must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 5.02. The Provider may elect to be reimbursed for major moveable and fixed Equipment by one of two methods:

a. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided Residents in the Nursing Facility. The Provider must maintain complete documentation in a fixed asset ledger, which clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first budgeted Nursing Facility Cost Report.

b. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment , the Division will not allow major moveable Equipment as part of the facility's allowable basis. The Division will allocate and allow fixed Equipment on a square footage basis.

3. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Facility within the hospital as Additions. The Div on will allocate capital expenditures related to the total plant on a square footage basis.

4. The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Facility. The Provider must allocate all costs shared by the hospital and the Nursing Facility using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics utilized in preparing the Nursing Facility Cost Report.

5. Except for provisions set forth in 114.2 CMR 5.03(3)(b) Hospital Based Nursing Facilities will not be treated differently than other Providers.

(4) Filing Deadlines.

(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Change of Ownership. The transferor must file Cost Reports within 60 days after a Change of Ownership. The Division will notify the Division of Medical Assistance if required reports are not timely filed for appropriate action by that agency.

2. New Facilities and Facilities with Major Additions. New Facilities and facilities with Major Additions that become operational during the Rate Year must file year end Cost Reports within 60 days after the close of the first two calendar years of operation.

3. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.

5.03: continued

4. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, § 72N, the Provider must file Cost Reports for the pre-receivership reporting period or portion thereof, within 60 days of the receiver's appointment.

(b) Extension of Filing Date. The Director of the Bureau of Long-Term Care may grant a request for an extension of the filing due date for a maximum of 45 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances which prevent the Provider from meeting the deadline; and
3. file the request no later than 30 calendar days before the due date.

(5) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information which the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by April 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(6) Amended Reports. The Division will not accept amended Cost Reports unless the Provider requests, in writing, that the Division correct a mechanical reporting error within ten calendar days of the date of the notice of Proposed Rates based upon the Cost Reports. At the same time, the Provider must also submit amended Report(s) clearly marked "CORRECTED" and signed by the Provider, a complete list of the changes requested, and sufficient documentation to support the requested corrections. The Director of the Bureau of Long Term Care will determine if an adjustment to correct such mechanical error and Proposed Rates is warranted.

(7) Additional Information. The Division may require the Provider to submit additional data and documentation during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports. In addition, the Division may request additional information and data relating to the operations of the Provider and any Related Party.

(8) Failure to File Timely.

(a) If a Provider does not file the required Cost Reports by the due date, the Division will delay certification of the rates for the next calendar year by 30 days for each 30 day period or any portion thereof that the reports are late. The Division will delay certification of rates only if the new rates are greater than the rates for the current year.

(b) If the Provider does not file the required Cost Reports or any other required information within six months of the due date, the Division will notify the Provider that it has not received the reports. If the Provider fails to file the required reports, the Division will terminate the Provider's rates effective the following January 1. The Division will rescind the termination when the Provider files the required reports.

5.04: Principles for Determining Prospective Rates of Payment

(1) General.

(a) Except for new facilities and facilities with Major Additions, as specified in 114.2 CMR 5.11, the Division will calculate prospective *per diem* rates for each Provider based upon the Provider's Base Year costs. In the case of Nursing Facilities which include Resident Care Units, the Division will establish a separate *per diem* rate for those beds licensed for Residential Care.

(b) Cost Centers. The Division will calculate the Provider's rates by summing the allowable *per diem* amount for each separate Cost Center. The methodology for computing the allowable *per diem* amounts for each Cost Center are set forth in the following sections of 114.2 CMR 5.00

5.04: continued

Nursing Costs	114. 2 CMR 5.05
Director of Nurses	114.2 CMR 5.06
Variable Costs	114.2 CMR 5.07
Motor Vehicle Costs	114. 2 CMR 5.07(3)
Administrative and General	114.2 CMR 5.08
Capital and Other Fixed Costs	114.2 CMR 5.09
Equity	114.2 CMR 5.10(a)
Use and Occupancy	114.2 CMR 5.10(b)

(2) Base Year. Except as provided below, the Base Year for 1997 rates is 1993.

(a) New Facilities and Major Additions. The Division will calculate rates for facilities with no Base Year cost history, including New Facilities, Facilities with Major Additions, and facilities which convert to nursing home use pursuant to 114.2 CMR 5.11.

(b) Facilities sold during the Base Year. If a facility was sold during the Base Year , the Division will use the buyer's Cost Reports for the buyer's period of ownership to determine allowable Base Year Costs unless the buyer 's period of ownership was of such short duration that it may not appropriately be used to project costs.

(c) Facilities closed after the Base Year. If a facility closed after the Base Year and subsequently reopened, the Division will use the Base Year Cost Report(s) to calculate the rates. If no Base Year Cost Report(s) were filed, the Division will use the latest Cost Report(s) for the facility filed prior to the Base Year. The Division will increase Reasonable Nursing and Variable Costs by an appropriate Cost Adjustment Factor.

(d) Facilities acquired by a Hospital. If a hospital acquires licensed Nursing Facility beds from a Nursing Facility, the hospital will be paid at the transferor's current rates. The transferor's Base Year costs will continue to be the basis for future rates until a year in which the hospital operated the beds becomes the Base Year under the regulation. If for any reason, the Base Year Cost Reports of the transferor have not been filed, the Division will use the latest Cost Reports of the transferor to calculate the rates. If licensed Nursing Facility beds are transferred to a hospital from more than one Nursing Facility, the Division will calculate a single set of rates for the transferee hospital by weighting the current rates of the transferors.

(e) Private Nursing Facilities. If a Nursing Facility which was a Private Nursing Facility in the Base Year and which timely filed a Base Year Cost Report, signs a provider agreement to provide services to publicly-assisted Residents in the Rate Year, the Division will use that Base Year Cost Report to calculate rates pursuant to the methodology set forth in 114.2 CMR 5.04 through 5.10. If the Provider did not timely file a Base Year Cost Report, the Provider must file a Base Year Cost Report in order for the Division to compute the rates.

(f) Facilities Purchased from a Receiver. Upon the sale of a facility in receivership, the Division may use a different Base Year Cost Report if the new owner demonstrates that a different Base Year more accurately reflects the reasonable and necessary costs of providing adequate resident care.

(3) Cost Adjustment Factor. The Division will increase Allowable Base Year Costs exclusive of all Fixed Costs by a Cost Adjustment Factor for 1993 through 1995 of 5.52% If there was a Change of Ownership in the Base Year , and the rates are based on the new owner's reported Base Year costs, the Division will modify the Cost Adjustment Factor to reflect the number of months from the midpoint of the new owner's reporting period to the midpoint of the prospective rate period.

(4) Rate Limitations.

(a) Medicare Upper Limit of Payment. The weighted average rates of payment may not exceed the amount that can be reasonably estimated to be paid for these services under Medicare principles of reimbursement unless the Division of Medical Assistance grants an exemption from the Medicare cost limits.

(b) Private Rate Limitation. The weighted average rates of payment may not exceed the rate charged by the Provider to private residents for the same or similar services and accommodations. The Division will calculate the private rate limitation as follows

5.04: continued

1. The Division will determine the weighted average publicly-aided prospective rates for the Base Year and compare it to the average private rate for the Base Year.
2. If the facility's weighted average rate is greater than the average private rate, the Division will reduce the prospective rates by an amount equal to the difference between the calculated rates and the private rate, multiplied by the number of private Patient Days.

(5) Audits. The Division will establish rates after a comprehensive Desk Audit of the Base Year Cost Report. The Division and Division of Medical Assistance will also, whenever possible, conduct on-site Field Audits to ensure the accuracy of the claims for reimbursement and consistency in reporting. Any cost for which the Provider does not produce documentation requested during a Desk or Field Audit will be disallowed.

(6) General Cost Principles. In order to be reimbursed, a cost must satisfy the following criteria:

(a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;
(b) The cost must adhere to the Prudent Buyer Concept;
(c) The cost must be for goods or services actually provided in the nursing facility; and
(d) The cost effect of transactions that have the effect of circumventing these rules are not allowable under the principle that the substance of the transaction prevails over form.
(e) The cost must actually be paid by the Provider. Examples of costs which are not considered paid for purposes of reimbursement include, but are not limited to: costs which are discharged in bankruptcy; costs which are forgiven; costs which are converted to a promissory note; and accruals of self-insured costs which are based on actuarial estimates;

(7) Non-Allowable Costs. The Division will not include in the rates those costs, as defined below, which are not reimbursable, are reimbursed through an allowance, or are for services which are billed directly.

(a) Non-reimbursable Costs:
1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;
2. Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;
3. Expenses that are not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;
4. Compensation and fringe benefits of residents on a Provider's payroll;
5. Any amounts in excess of any schedule of limitation contained in 114.2 CMR 5.00;
6. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;
7. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;
8. The amount by which the total compensation package, including payroll taxes and benefits, for any individual, except those individuals covered by the Administrative and General Allowance, exceeds $75,000 per annum.
9. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies that are not registered with the Department under regulation 105 CMR 157.000;
10. Any expense or amortization of a capitalized cost which relates to costs or expenses incurred prior to the opening of the facility.
11. All legal expenses, and those accounting expenses and filing fees associated with any appeal process

(b) Costs reimbursed through an allowance or other specified methodology.
1. Administrative and General Costs as set forth in 114.2 CMR 5.08.
2. Capital and Other Fixed Costs, as set forth in 114.2 CMR 5.09.

5.04: continued

3. Motor Vehicle expenses as set forth in 114.2 CMR 5.07(3);
4. Working Capital interest as set forth in 114.2 CMR 5.08(c)(1).

(c) Costs for services which are billed directly: The following supplies or services must be billed directly to the purchaser in accordance with the purchaser's regulations or policies.

1. Direct physician services to the individual residents, including emergency physician services required by the Department pursuant to 105 CMR 150.000.
2. Medical Supplies.
3. Pharmacy costs related to legend drug prescriptions and prescribed legend drugs for individual residents.
4. Direct Restorative Therapy services, except for Pediatric facilities.
5. The Division may include ancillary services and supplies in the rates in accordance with the regulations or written policy of the purchasing agency.

(8). Special Provisions.

(a) Accrued Expenses. The Division will not allow accrued expenses which remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals permissible under 114.2 CMR 5.04(8)(b)2. If the Provider submits satisfactory evidence of payment, the Division may reverse the adjustment and include that cost, if otherwise allowable, in the applicable rates.

(b) Employee Benefits. Employee Benefits include but are not limited to group health and life insurance, pension plans, seasonal bonuses, child care, and job related education and staff training. The Division will allow only the Provider's contribution of Generally Available Employee Benefits. Providers may vary Generally Available Employee Benefits by groups of employees at the option of the employer.

1. Benefits related to salaries. The Division will limit benefits related to salaries to allowable salaries.
2. Accrued employee benefits. Providers may accrue expenses for employee benefits such as vacation, sick time, and holidays that employees have earned but have not yet taken when a legal liability to pay such expenses is established. The Provider may accrue such expenses only if:
   a. the benefits are stated in the Provider's written employment policy;
   b. it is the Provider's actual practice to pay such benefits; and
   c. the benefits are guaranteed to the employee even upon death or termination of employment.
3. Job-related Education and Staff Training Expense. The Division will allow the net cost of the Provid[illegible]'s contribution to the cost of required educational activities, job-related education, and staff training of employees if the educational and training activities are conducted within the New England region or New York State, are conducted by a recognized school or other authorized organization, and are directly related to improving care to Publicly-Aided Residents. In order to be reimbursed, the facility must maintain records of the expenses including the names of the schools or other organizations sponsoring the educational activity, the names and positions of employees attending, the date and location of the activity; the number of Continuing Professional Credits earned, if any, and a copy of the outline of the subjects covered.
   a. All programs designed to satisfy the nurses' aide training requirement must be certified by the Department.
   b. The net cost is the cost of required educational activities less any reimbursement from grants, tuition, specific donations, employee contributions, or other sources.
   c. Education expenses for Administrator-in-Training are not reimbursable.
   d. Education expenses for Continuing Education Credits for licensed administrators are covered by the Administrative and General Allowance.
4. Bonuses. The Division will not reimburse bonuses related to profit, private occupancy, or to rates of reimbursement.
5. Pension Plans. The Division will reimburse reasonable and necessary expenses relating to a pension plan, subject to the reasonable cost limits set forth in 114.2 CMR 5.00, only if the pension plan provides for either a fixed, determinable amount to be contributed by the employer on a regular basis or for a fixed, determinable benefit to be received by the employee at retirement.

5.04: continued

a. Pension Plans Required by State Statute. The Division will reimburse Providers required by statute to make payments to municipal or county pension funds for the pension benefit paid by the plan to the retirees of the Nursing Facility covered by the plan. In order to be reimbursed, the Provider must provide documentation of the allocations provided to the Public Employees Retirement Administration. If the plan is a funded plan, the Provider must also submit a schedule of the individuals associated with the Nursing Facility.

b. Pension Plans Not Required by State Statute. The Division will reimburse reasonable and necessary expenses relating to a pension plan if:

i. the claimed expenses represent an amount based upon fair, reasonable, and necessary compensation for services performed by employees;

ii. the claimed expenses are costs incurred on the current year payrolls and do not include payments for prior year payrolls;

iii. the pension plan does not provide for contributions by the employer based on a contingency of profit or at the discretion of the employer;

iv. any forfeiture by an employee must be applied against the cost of the pension plan to reduce the premiums paid by the employer;

v. the pension plan must have met the current requirements of and, if applicable, must have received the approval of the Internal Revenue Service. The Provider must file a copy of the pension plan and all applicable Internal Revenue Service forms documenting IRS approval.

(c) Equipment Rental. The Division will allow expense to rent or lease office equipment located at the facility if the expense is reasonable and necessary and contributes to Provider efficiency.

(d) Expenses which generate income. The Division will offset expenses by applicable income which includes, but is not limited to, rental of quarters to employees or others; income from meals sold to non-residents; vending machine income; and medical records income. The Division will offset vending machine income against Variable Costs. Other income will be offset against an account in the appropriate Cost Center. If the Provider has not separately identified the cost of providing laundry services to private residents as required by 114.2 CMR 5.03(2)(f)3., the Division will offset laundry income against laundry expense.

(e) Payments to Related Parties. The Division will not allow payments to a Related Party unless the Provider identifies both the expenses paid to the Related Party and the cost incurred by the Related Party to provide the goods or services to the Provider. The Division will limit reimbursement of expenses paid to a Related Party to the lower of a Related Party's cost of providing the goods or services or the market price of comparable goods or services. The Division may require the Provider or Related Party to submit documentation relating to Related Party expenses and costs.

(f) Services of Non-Paid Workers. The net value of services of non-paid persons in positions customarily held by paid employees, who perform such services on a regular basis as non-paid members of religious or other organizations must be allowable for reimbursement purposes under 114.2 CMR 5.00. The value of the services normally provided on a voluntary basis, such as distribution of magazines and newspapers to residents, must not constitute an allowable cost. To qualify as an allowable cost, services of non-paid workers must meet the following requirements:

1. The amount allowed may not exceed that which would be paid others for similar work;

2. The amount paid by the Provider to the organization must be identifiable in the records of the Provider as a legal obligation;

3. The services must be performed under an agreement between the organization and the Provider for the performance of the services without direct payment from the Provider to the member.

4 The services must be performed on a regular, scheduled basis and must be necessary for the provision of adequate resident care to Publicly-Aided Residents and for the efficient operation of the Provider.

5 The services must be fully disclosed on the Footnotes and Explanations page of the Cost Report. Both the total expense and the account(s) in which the expense is reported must be identified.

5.04: continued

Example: Assume that the prevailing salary of a registered nurse is $22,000 per year for full-time services. A non-paid worker, as described above, receives maintenance and other benefits equal to a value of $5,000 but no salary. The Provider would then include in its records an additional $17,000 to bring the value of the services rendered up to $22,000. The amount of $17,000 would be allowable where the Provider assumes an obligation for the $5,000 expense under a written agreement with the organization for payment by the Provider of the services.

(g) Therapy Services - Indirect. Indirect Restorative Therapy services are reimbursable provided that such service is documented in a written summary, available for inspection in the facility. This summary should be in the form of a consultant log book for each discipline and should be updated at least monthly.

(h) Rates for Innovative and Special Programs. The Division will include an allowance for costs and expenses to establish and maintain an innovative program for providing care to Publicly-Aided Residents if:

1. The Provider has received prior written approval from the Department of Elder Affairs to establish and maintain a program; or

2. The Provider participates in a special program pursuant to a contract with the Division of Medical Assistance under which it has agreed to accept residents designated by that agency.

(9) Retroactive Adjustments. The Division may retroactively adjust rates in certain situations which include, but are not limited to, the following.

(a) Accrued but Unpaid Expenses. If the Division learns that a Provider has failed to pay expenses which were accrued at the end of the Base Year and which were reimbursed in the rates, the Division may adjust the rates downward to remove such expenses. This does not apply to permissible vacation and sick time accruals, as defined in 114.2 CMR 5.04(8)(b)2.

(b) Errors in the Cost Reports. The Division may adjust rates if it learns that the Provider has made an error in the cost report which results in a material over-reimbursement to the Provider.

(c) Mechanical Errors. The Division may adjust rates if it learns that there is a material error in the rate calculations.

(d) Field Audit. The Division will adjust rates to reflect the results of field audits conducted by the Division or the Division of Medical Assistance.

(e) Termination of Receivership. The Division will adjust rates to reflect allowable receivership expenses as defined in 114.2 CMR 5.12(6)(d).

(f) New Facilities and Major Addition Look-Back Provisions. The Division will adjust rates to reflect the Look-Back Provisions as defined in 114.2 CMR 5.11.

(g) Administrative Adjustments. The Division will adjust rates to reflect allowable administrative adjustments as defined in 114.2 CMR 5.12.

5.05: Nursing Costs

The Division will calculate ten case mix adjusted nursing *per diem* rates based upon a facility's reasonable Base Year nursing costs and Base Year case mix data.

(1) Determination of Reasonable Nursing Costs

(a) Nursing Costs. The costs must be associated with direct resident care personnel, be required to meet federal and state laws, and meet the general cost conditions set forth in 114.2 CMR 5.04. Nursing costs include, but are not limited to, the claimed Base Year costs for Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Nursing Workers Compensation, Nursing Payroll Tax , and Nursing Fringe Benefits, including Nursing Pension Expense.

(b) Nursing Ceiling

1. The Division will calculate a Nursing Ceiling based upon claimed Base Year average nursing cost per management minute as follows:

a. The Division will calculate a nursing *per diem* for each facility by dividing the facility's claimed Base Year nursing costs by the greater of Base Year patient days or 96% of the Mean Licensed Bed Capacity in the Base Year times the days in the Base Year.

5.05: continued

b. The Division will calculate the Base Year average nursing cost per Management Minute for each facility by dividing the Base Year nursing cost *per diem* by the facility's Base Year average Management Minutes score from the Case Mix Data.

c. The Division will group Providers into three NHRAs as defined in 114.2 CMR 5.02.

d. The Division will calculate a Nursing Ceiling for each NHRA. The ceiling is 110% of the median claimed Base Year nursing cost per Management Minute incurred by facilities in each NHRA.

2. The Division will not allow Base Year nursing costs which exceed the facility's NHRA nursing ceiling, except that the Division will not apply the nursing ceiling to Pediatric Nursing Facilities.

(2) Calculation of Ten Nursing *Per Diem* Rates.

(a) The Division will compare the facility's average Base Year nursing cost per management minute to the appropriate nursing ceiling. The facility's allowable Base Year nursing cost per management minute is the lower of the facility's average nursing cost per management minute or the nursing ceiling.

(b) The Division will determine the case mix adjusted Base Year nursing *per diem* rates by multiplying the facility-specific mean minutes per case mix category from the Case Mix Data by the facility's allowable nursing cost per Management Minute. If the facility-specific mean minutes per case mix category equals zero, the Division will use the industry median minutes for that category, as derived from the Case Mix Data.

(c) The 1997 Nursing Rates are the case mix adjusted Base Year nursing home rates increased by the Cost Adjustment Factor, and increased by an additional 5.43%

5.06: Director of Nurses Costs

The Division will calculate a Director of Nurses *per diem* based upon the Provider's reasonable Base Year Director of Nurses costs.

(1) Director of Nurses Costs include Base Year costs for Director of Nurses salary, fringe benefits including pension, payroll taxes and workers compensation, and any other cost associated with the Director of Nurses.

(2) Reasonable Base Year Director of Nurses Costs are the lower of total Base Year Director of Nurses costs or $75,000.

(3) The Division will determine 1997 Allowable Director of Nurses Costs by increasing reasonable Base Year Director of Nurses Costs by the Cost Adjustment Factor and an additional 5.43%.

(4) The Division will divide Allowable Director of Nurses Costs by the greater of:

(a) 96% of current Licensed Bed Capacity for the Rate Year times the days in Rate Year or

(b) the Actual Utilization Rate in the Base Year.

5.07: Variable Costs

The Division will calculate an allowable Variable Cost *per diem* based upon the Provider's reasonable Base Year Variable Costs.

(1) Variable Costs include, but are not limited to, the following:

(a) Total Plant, Operations and Maintenance;

(b) Total Dietary, including allowable Management Company Dietitian cost;

(c) Total Laundry;

(d) Total Housekeeping;

(e) Ward Clerks and Medical Records Librarian;

(f) Medical Director;

(g) Advisory Physician.

5.07: continued

(h) Utilization Review Committee;
(i) Employee Physical Exams;
(j) Other Physician Services;
(k) House Medical Supplies Not Resold;
(l) Pharmacy Consultant;
(m) Social Service Worker;
(n) Indirect Restorative and Recreation Therapy Expense;
(o) Other Required Education;
(p) Job Related Education;
(q) Quality Assurance Professionals;
(r) Management Minute Questionnaire Nurses; and
(s) Staff Development Coordinator

(2) Allocation of Parallel Accounts. Variable Costs also include an allocation of certain Base Year expenses associated with the following salary "parallel accounts": Non-Nursing Pensions; Non-Nursing Benefits - Other; Payroll Taxes - Non-Nursing; Worker's Compensation - Non-Nursing; Group Life/Health - Non-Nursing; and Non-Profit DES Claims. The Division will determine the allocation as follows:

(a) The Division will add the costs in the claimed Base Year parallel accounts;
(b) The Division will add the costs associated with the Non-Nursing salary accounts;
(c) The Division will determine the "parallel account factor" which is the percentage of non-nursing parallel accounts to total non-nursing salary accounts.
(d) The Division will allocate a portion of the parallel accounts to the Administrative and General Cost Center by multiplying the parallel account factor by the sum of the claimed Base Year salary accounts for clerical staff and Administrator in Training. The Division will allocate the remaining portion of the parallel accounts to the Variable Cost Center.

(3) Motor Vehicle Allowance. The Division will not include Motor Vehicle expenses as allowable Variable Costs. Motor vehicles include, but are not limited to, automobiles, trucks, vans, buses and tractors. Motor vehicle expenses include, but are not limited to, depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax. The Division will include a motor vehicle allowance of $1,500 in lieu of all motor vehicle expenses. The Motor Vehicle *per diem* allowance is calculated by dividing $1,500 by Rate Year Licensed Bed Capacity times the days in the Rate Year times the greater of 96% or the Actual Utilization Rate in the Base Year.

(4) Variable Cost Ceiling. The Division will calculate a variable cost ceiling as follows:

(a) The Division will group a representative sample of facilities into four groups:
1. Group 1 = Facilities in Case-Mix Group-Light and located in Health Service Area 4;
2. Group 2 = Facilities in Case-Mix Group-Heavy and located in Health Service Area 4;
3. Group 3 = Facilities in Case-Mix Group-Light and located in Health Service Areas 1, 2, 3, 5 and 6; and
4. Group 4 = Facilities in Case-Mix Group-Heavy and located in Health Service Areas 1, 2, 3, 5 and 6.

(b) The Division will calculate a Variable Cost Ceiling for each group. The ceiling is 108% of the median claimed Base Year costs reported by a representative sample of Providers in each group.
(c) The Division will not allow Base Year Variable Costs which exceed the facility's Group ceiling.

(4) Determination of Allowable Variable Cost

(a) The Division will calculate reasonable Base Year Variable Costs by comparing the claimed Base Year costs, subject to the limitations set forth in 114.2 CMR 5.04, to the appropriate ceiling. The Division will allow the lower of the Provider's Base Year Variable Costs or the variable ceiling.

5.07: continued

(b) The Division will calculate 1997 allowable Variable Costs by increasing reasonable Base Year Variable Costs by the cost adjustment factor and increasing the result by 5.43%.
(c) The Division will calculate an allowable variable cost *per diem* by dividing allowable Variable Costs by the greater of Base Year Patient Days or 96% of the Mean Licensed Bed Capacity in the Base Year times the number of days in the Base Year .

5.08: Administrative and General Allowance

The Division will include in each Provider's rates an Administrative and General Allowance to reimburse Administrative and General Costs.

(1) Administrative and General Costs. Administrative and General Costs include all expenses relating to the following:

(a) On-site Staff. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility.

(b) Administrative Oversight Function. Expenses related to tasks performed by persons at a management level above that of an on-site facility department head, which are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility. All costs for off-site Buildings and Equipment, office supplies, telephone, conventions and meetings, help wanted advertisement, license and dues, malpractice insurance, legal, accounting, financial and managerial services or advice including computer services and payroll processing are included. Expenses of a parent organization, management company or central office are also included to the extent that such expenses reflect costs for the above mentioned services and are related to the provision of care to Publicly-Aided Residents in Nursing Facilities located in the Commonwealth.

(c) Policy Planning Function. The policy-making, planning and decision-making activities necessary for the general and Long-Term management of the affairs of a Nursing Facility, including but not limited to the following: the financial management of the facility, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies and the planning of the expansion and financing of the facility.

(d) Administrative and General Costs include the amounts reported in the following accounts:

1. the portion of the "parallel accounts" allocated to the Administrative and General Allowance pursuant to 114.2 CMR 5.07(2);
2. Administrator Salaries;
3. Payroll Taxes - Administrator;
4. Worker's Compensation - Administrator;
5. Group Life/Health - Administrator;
6. Administrator Pensions;
7. Other Administrator Benefits;
8. Clerical, prior to adjustment of self-disallowed amounts;
9. EDP/Payroll/Bookkeeping Services;
10. Administrator-in-Training;
11. Office Supplies;
12. Phone;
13. Conventions and Meetings;
14. Help Wanted Advertisement;
15. License and Dues, Resident Care Related;
16. Education and Training - Administration;
17. Accounting - Other;
18. Insurance - Malpractice;
19. Other Operating Expenses ;
20. Realty Company Variable Costs;
21. Management Company allocated Variable Costs; and
22. Management Company allocated Fixed Costs

5.08: continued

(2) Base Year Administrative and General Cost. The Division will calculate the Base Year Administrative and General *per diem* cost for each Provider by dividing Total Claimed Base Year Administrative and General Costs by the greater of: Base Year Patient Days or 96% of Base Year Mean Licensed Bed Capacity multiplied by days in the Base Year. For multi-level nursing facilities with Resident Care Units, Base Year Reported Patient Days includes Resident Care days and Base Year Mean Licensed Bed Capacity includes Resident Care Beds.

(3) Administrative and General Allowance. For rates effective January 1, 1997, the Division will establish an allowance for Administrative and General Costs of $9.74 *per diem*.

(4) Efficiency Incentive. If a Provider's Base Year *per diem* Administrative and General Cost is less than the allowance, the Administrative and General Allowance will be its Base Year *per diem* Administrative and General Cost adjusted by the Cost Adjustment Factor plus 25% of the difference between the allowance and the Provider's Base Year *per diem* Administrative and General Cost.
Example. A facility with a Base Year Administrative and General Cost *per diem* of $6.39, will have an Administrative and General *per diem* Allowance of $7.58; {[($6.39 times 1.0552)] plus [($9.74 - 6.39) times 0.25]}

5.09: Capital and Other Fixed Costs

To determine allowable capital and other fixed costs, the Division will classify Providers into two groups. There is a separate method of reimbursement for each group. Method One is set forth in 114.2 CMR 5.09(3). Method Two is set forth in 114.2 CMR 5.09(4).

(1) Provider Classifications.
(a) Method One. The Division will calculate allowable Capital and Other Fixed Costs pursuant to Method One if the facility:
1. was operational in 1995 and does not request an Administrative Adjustment for a Substantial Capital Expenditure or Major Addition on or after January 1, 1996; or
2. opened on or after January 1, 1996 pursuant to a Determination of Need approved by the Department by March 7, 1996;
3. requested an Administrative Adjustment for a Substantial Capital Expenditure on or after January 1, 1996 pursuant to a Determination of Need or Final Plan approved by the Department by March 7, 1996; or
4. requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).
(b) Method Two. The Division will reimburse capital costs pursuant to Method Two if the Provider opened after January 1, 1996 or requested an Administrative Adjustment for a Substantial Capital Expenditure pursuant to a Determination of Need or Final Plan either issued or transferred after March 7, 1996.
(c) Transfer of Department Approvals. Unless a Notice of Intent to Acquire the facility was filed with the Department by March 7, 1996, the transferee's capital reimbursement will be determined pursuant to Method Two when the capital project subject to the approval becomes operational.

(2) Allowable Basis of Fixed Assets. The Allowable Basis of Fixed Assets is used to calculate allowable depreciation, interest, equity, and use and occupancy for Method One and the Capital Allowance for Method Two.
(a) Fixed Assets.
1. Fixed Assets include Land, Building, Improvements, Equipment and Software.
2. Allowable Additions. The Division will reimburse Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions relate to a capital project for which the Department has established a Maximum Capital Expenditure, reimbursement is limited to the amount approved by the Department. The Division will not reimburse any Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.

5.09: continued

(b) Facilities operational in 1996.

1. Beginning Basis. The Allowable Basis of Fixed Assets effective January 1 is the Allowable Basis of Fixed Assets effective December 31 of the prior year.

2. Ending Basis. The Allowable Basis effective December 31 is the Beginning Basis plus Allowable Additions less fixed assets which were fully depreciated or removed from service during the year.

(c) New Facilities and Major Additions. The allowable basis of fixed assets for new facilities and facilities with major additions in the Rate Year are the reasonable construction costs as determined below.

1. Capital projects subject to an approved Determination of Need process. For new facilities which become operational in 1997 or facilities which renovate and replace beds pursuant to a DON approval, the Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.

2. Capital projects which are not subject to the Determination of Need process.

a. Urban Underbedded Areas. For facilities located in Urban Underbedded Areas exempted by the Department from the Determination of Need process, the Division will determine the Maximum Capital Expenditure of newly-constructed facilities pursuant to the methods and criteria utilized by the Department as set forth in 105 CMR 151.000 (*General Standards of Construction of Long Term Care Facilities*) effective 180 days after final construction plans were approved by the Department or the date on which the construction contract was signed, whichever is earlier. In determining the MCE, the Division will determine the reasonable costs of construction, land acquisition and development, pre-and post-filing planning and development, financing and major moveable equipment. For new construction the purpose of which is to replace beds or substantially renovate the existing facility, the Division will determine the Maximum Capital Expenditure pursuant to the Department's Determination of Need Guidelines for Nursing Facility Replacement and Renovation, dated May 25, 1993. All urban underbedded projects require a 10% equity contribution by the applicant.

b. Twelve Bed Additions. If a facility makes a twelve-bed addition which is exempt from the Determination of Need process simultaneously with the construction of a project subject to Determination of Need approval, the allowable Basis is the lower of the provider's actual cost per bed or the cost per bed derived from the Department's Maximum Capital Expenditure amounts for each category of assets for the Determination of Need project.

(d) Free-standing Buildings converted to Nursing Facility Use. The Allowable Basis of Fixed Assets is the Net Book Value (the cost to the current owner less accumulated depreciation which would have been allowed had the building been used in the Medicaid Program since construction).

1. Land: the original cost of the land to the current owner.
2. Building: the net book value (depreciated over 40 years with no equity supplement).
3. Improvements: the net book value of improvements made less than 20 years before conversion (depreciated over 40 years);
4. Equipment: the net book value of equipment purchased less than ten years before conversion (depreciated over ten years).

(e) Hospital Buildings converted to Nursing Facility Use. The Allowable Basis of Fixed Assets will be calculated using the DHCFP-403 Cost Report exclusive of any assets which are not appropriate or necessary for nursing care facilities such as, but not limited to, laboratories and x-ray Equipment.

(f) Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:

1. Land. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis.

5.09: continued

2. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June, 30, 1976 and 1993 forward. In addition, the seller's allowable Building Improvements will become part of the Allowable Building Basis of the new owner.

3. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates. The seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

4. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

5. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

6. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.

(g) Special Provisions.

1. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

2. Repossession by Transferor. The Division will recompute Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership , increased by any allowable capital Improvements made by the transferee since acquisition, and reduced by depreciation since acquisition.

(3) Method One. Under Method One, the Division will reimburse Allowable Base Year Fixed Costs including depreciation, interest, real estate taxes, the Non-income portion of the Massachusetts Corporate Excise tax, Building insurance and Equipment rental as defined below:

(a) Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment, but reimbursement is limited to the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.

(b) Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets.

1. Methodology. Allowable Depreciation is calculated using the straight line method.

5.09: continued

2. Useful Lives. Except as provided below, Allowable Depreciation is calculated using the following useful lives:

ASSET	TYPE	USEFUL LIFE	DEPRECIATION RATE
Building	Class I or II as classified by the Department of Public Safety	40	2.5%
	Class III or IV as classified by the Department of Public Safety	33	3.0%
	A Building owned and operated by a political subdivision of the Commonwealth or an authority or which was financed by municipal bonds.	20	5%
Building Improvements	Building or leasehold Improvements made subsequent to the beginning of the Rate Year must be pro-rated over the life of the lease or the balance of the estimated life of the Building as determined above, but in no case to exceed the yearly rate of 5%.	Various	up to 5%
Equipment, Furniture and Fixtures		10	10%
Motor Vehicle Equipment		4	25%
Software		3	33.3%

3. Change of Ownership.

a. If there was a Change of Ownership prior to 1983, the allowable depreciation is calculated pursuant to the regulation in effect for the year in which the Change of Ownership occurred.

b. If there is a Change of Ownership on or after January 1, 1983, the allowable basis of Building and Building Improvements is depreciated over the remaining useful life plus the number of years that Building depreciation was not recaptured in determining the allowable basis for the new owner. The annual amount of depreciation on the assets that have been transferred may not exceed the amount allowed to the immediate prior owner.

(c) Working Capital Interest. Interest on short term working capital is not allowable in the calculation of the prospective rates. In lieu of these costs, the Division will include a working capital allowance for the financing of current operations. The allowance is determined by multiplying the facility's weighted average case-mix adjusted rate (less fixed costs, miscellaneous adjustments for inflation, return on equity, and the use and occupancy allowance) by 1/12 of 7.75%.

(d) Long Term Interest Expense.

1. Reimbursable Debt.

a. Subject to the limitations on refinancing set forth in 114.2 CMR 5.09(3)(d)1.b., the Division will recognize a long term debt as reimbursable if it is obtained to finance assets used in the care of publicly-assisted patients and if it is supported by allowable depreciable fixed assets.